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Psychological Issues in Peacekeeping Contingency Operations¹

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Paper presented at the annual meeting of the American Psychological Association, Los Angeles, CA, August 1994.

¹The views of the authors do not purport to reflect the position of the Department of the Army or the Department of Defense (PARA 4-3, AR 360-5).

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Abstract

While much is known about soldier stress and adaptation in more conventional military operations, the U.S. military has little experience with United Nations-led peacekeeping missions. How combat-trained units and soldiers adapt to this new role is of critical importance to U.S. ability to contribute positively to such operations. Since October of 1992, as part of Operation Provide Promise, the U.S. Army in Europe has provided medical care for the 25,000 UNPROFOR (United Nations Protection Forces) soldiers located in the former Yugoslavia. Using a longitudinal approach and multiple methods, the present research identifies the key sources of stress before, during, and after the 6-month deployment, and assesses the impact of these stressors on soldier health and morale.

Psychological Issues in Peacekeeping Contingency Operations

Responding to the perceived value of "human dimensions" field research in major U.S. military operations such as the Gulf War, the Army's Office of the Surgeon General directed the U.S. Army Medical Research, Development, Acquisition and Logistics Command to provide "Human Dimensions in Combat" research (HDCR) teams for future mobilizations and deployments (Human dimensions in combat research mission, 1993). The mission of HDCR teams is: "In periods of mobilization, deploy with U.S. forces and perform observational research and consulting on topics of stress, coping, adaptation, morale and unit cohesion" (Establishment of Human Dimensions in Combat Research Unit, undated). The U.S. Army Medical Research Unit - Europe (USAMRU-E) in Germany, a Special Foreign Activity of the Walter Reed Army Institute of Research, conducts behavioral science research on soldier and family stress and adaptation in a forward-deployed force. As U.S. Army forces in the post-Cold War Europe assume more contingency and peacekeeping operations throughout the European theater and Africa, USAMRU-E has adapted the HDCR concept to such operations.

While much previous research has been done on soldier stress and adaptation in more conventional military operations, the U.S. military has little

experience with United Nations peacekeeping missions. How combat-trained units and soldiers adapt to this new role is of critical importance to U.S. ability to contribute positively to such operations. In November of 1992, the U.S. Army was given the mission to provide medical support to the 25,000 United Nations peacekeeping forces operating in the former Yugoslavia as part of Operation Provide Promise. USAMRU-E researchers collected observational data from this unit on a variety of human dimensions issues. In March of 1993 another U.S. Army unit in Germany was identified as the next to deploy for this mission. Preliminary results from the longitudinal investigation of "human dimensions" issues in the deployment of this second Army medical task force are presented here.

Method

Pre-Deployment

In March of 1993 a specially-configured U.S. Army task force of about 300 soldiers in Germany was identified as the next unit to provide medical support for 25,000 United Nations peacekeeping forces operating in the former Yugoslavia. Data collection with this unit began in the pre-deployment phase, during a two-week training period just prior to their actual deployment to Croatia and included 74 semi-structured interviews and 188 self-report surveys

completed by soldiers. The semi-structured interviews were done primarily on an individual basis although a few were done in small groups of two to three soldiers. Two teams of two persons each were used for this phase of the data collection. Extensive observations of key events were also conducted throughout this period, such as a command-sponsored unit leader seminar, and the immediate pre-deployment "lock-in" period and departure ceremony.

Early-, Mid- and Late- Deployment

A two-person "Human Dimensions Research Team" made a total of four data collection site-visits to the unit in Croatia over the course of the deployment, staying for 7-10 days per visit. The first visit covered the initial arrival and transition period (April 1993), with subsequent visits 2-months and 4-months into the deployment. The third visit utilized a larger research team of four members, and included an administration of a mid-deployment survey to 128 soldiers (about 60% of the unit available), 37 semi-structured interviews and additional observations. The final visit occurred about two weeks prior to redeployment in early October 1993, and included a brief survey administered to 81 soldiers, or about 50% of the soldiers available at that time.

Data Collection

The pre-, mid-, and late- deployment surveys and interview schedules

covered three general areas: 1) sources of stress; 2) physical and mental health outcomes (including morale and cohesion); and 3) individual and organizational factors that might influence responses to stress. We also assessed soldier perception of the multi-national operational environment. A simultaneous study was also conducted on the spouses of deployed soldiers in order to identify rear detachment and family issues. These data are presented elsewhere (Adler, Bartone, Vaitkus, 1994).

Results

Pre-deployment

Though built around an existing core element, the medical unit was specially constituted to serve the peacekeeping mission. While common for deploying units to have personnel and equipment specially tailored for the mission, the situation was especially difficult for this unit due to the small size of the core element. Personnel for the unit, which increased in size from about 40 to 200 people, were drawn from a wide geographical area in Germany. There was considerable confusion early on regarding the composition of the unit. Many of the soldiers were strangers to one another, and most key leaders were new in their jobs and not yet recognized by the soldiers. A debate among senior commanders about total number to assign to the unit created additional

uncertainty that was not resolved until shortly before the actual deployment. Thus, many unit trainees were unsure about whether they would actually deploy or not.

Overall, the major stress factors in the pre-deployment phase were concerns about the Army drawdown and cuts, getting ready to deploy, changes in unit leadership, and family members, particularly for soldiers drawn from outlying areas (Table 1). The concern about family members was frequently related to the loss of services in some communities as a result of the drawdown of Army forces in Europe.

Insert Table 1 About Here

Early- and Mid-deployment

During the early- and mid-deployment phase, a critical stress factor was the lack of meaningful activities in which soldiers could engage. This was frequently described as "boredom." The daily patient census in the hospital was low, and travel restrictions prevented U.S. medical personnel from doing outreach and liaison work in any of the forward sectors. There was also a growing sense of isolation associated with the perceived lack of responsiveness

from rear support elements to requests for supplies and replacement personnel. This was apparently exacerbated by a lack of media attention to the UNPROFOR medical support mission. For many of the married soldiers, despite fairly good mail and telephone service, concern for families back home was a major issue. This concern was often linked to the poor attempts of some rear detachment elements to keep in touch with family members. Finally, many perceived an unfair distribution of rewards and resources, such as special U.N. pay, awards, supplies, and access to vehicles, leading to a sense of deprivation relative to soldiers from other nations, and, occasionally, to other American troops not assigned to the hospital.

In terms of individual stressors, the items of most concern included missing one's spouse, uncertainty about the unit's future location, and Army drawdown and cuts (Table 1). Both uncertainty and the drawdown were rated as more stressful than during the pre-deployment period. Lack of access to transportation and boredom were also reported to be stressors, perhaps related to a growing restlessness with the lack of perceived meaningful activities.

Late-deployment

The key stressors in the final period also involved uncertainty and ambiguity. The unit's future location was still unknown, leaving many soldiers

wondering where they would redeploy to, and whether they would have to move their families. There was a continued sense of relative deprivation, and ambiguity about the mission itself and its value. While the opportunity to treat a small number of civilian "humanitarian" patients at the hospital was welcomed by the staff, it also led to increased questions about why more humanitarian medical care was not permitted. During this period there was also an increased security threat, as nearby targets came under Serbian artillery attack. This clearly increased tension levels for a time, although it had some positive effects as well with respect to the perception of the mission's importance. It added a sense of "the nearness of war" to the environment, and the greater media attention that followed was generally welcomed by the soldiers. The attack may also have worked to increase or at least maintain unit cohesion as soldiers labored together to strengthen perimeter defenses in the face of a common external threat. The general level and type of concerns seen during the mid-deployment persisted into the late-deployment phase (Table 1).

Trends Over Time

Throughout the deployment, soldiers reported high levels of concern about the drawdown and its associated uncertainty for their units and families. Soldiers also reported high levels of stress associated with missing their

spouses, boredom and restlessness. Thus, despite specific concerns relative to the deployment, larger drawdown issues were a persistent stressful theme.

Detailed analysis of the survey and interview data will identify more precisely the positive and negative influences on soldier morale, health and well-being.

In terms of the international setting, soldiers became increasingly frustrated with the support they received from the UN. During the mid-deployment, 15.2% rated UN support for the mission as bad or very bad. By the late-deployment, dissatisfaction rose to 23.8%. In general, relations with troops from other nations were positive, although there was a slight decline at the late-deployment period (Figure 1). Relations with local Croatians and French troops were relatively less positive. Although there were isolated incidents of conflict involving local Croatians and other nations' soldiers, about half (51.2% at mid-deployment and 48.8% at late-deployment) reported neutral relations, perhaps reflecting UN policy that peacekeepers remain neutral. Relations with French troops were more negative than neutral (34.9% at mid-deployment and 37.0% at late-deployment reported bad or very bad relations). Despite individual initiatives at contact, soldiers reported a general perception that the French were relatively uninterested in social contact with other nations' forces.

Insert Figure 1 About Here

Survey data show that unit morale and cohesion were at a high during the pre-deployment phase, declined somewhat over the early part of the deployment, and then held rather steady (Figures 2 & 3). The interview data reveal that initial levels of morale and cohesion were influenced in part by an excitement and enthusiasm for the special medical peacekeeping mission, the "chance to make a difference," and the chance to implement training. As the deployment progressed, decline in morale and cohesion may have been influenced by the relative lack of meaningful work activity. The interview data suggest, however, that morale and cohesion remained moderately high overall partly as a function of the shared perception that key unit leaders were doing their best to care for soldiers and keep them well-informed.

Insert Figure 2 About Here

Insert Figure 3 About Here

In interpreting the results, it is important to remember that the mission required a collection of specialized work sections with very different responsibilities, from clinical staff to motor pool workers. Cohesion appeared very high in some sections, but quite low in others. Soldiers rated their personal morale higher than unit morale, perhaps reflecting their ambivalence about their unit's effectiveness (Figure 4). Further analyses will focus more on cohesion within work sections.

Insert Figure 4 About Here

Discussion

This preliminary analysis of data collected during a U.S. Army peacekeeping deployment demonstrates the viability and value of conducting "Human Dimensions" research in contingency or peacekeeping operations. Such missions are becoming more common for the U.S. military, and the sources of stress on soldiers are not identical to those found in more traditional

"combat" operations. Applying multiple data collection methods over time has allowed us to identify the key stressors at various phases of an entire operation, and begin to understand the factors that are influencing soldier morale and mental health. As the U.S. military force shrinks, the active utilization of deployable "Human Dimensions" research teams will help assure optimized performance from our human resources.

References

- Adler, A.B., Bartone, P.T., & Vaitkus, M.A. (1994, August). Family stress and adjustment during a peacekeeping deployment. Poster presented at the American Psychological Association Annual Meeting, Los Angeles.
- Establishment of human dimensions in combat research unit. (undated). Draft Memorandum of Understanding between the Department of the Army Deputy Chief of Staff for Personnel and the Office of the Surgeon General.
- Human dimensions in combat research mission. (1993, July 9). Memorandum, U.S. Army's Office of the Surgeon General.

Table 1
Mean Stressor Ratings Over Time

Stressors	Deployment Phase ¹		
	Pre- ²	Mid- ³	Late- ⁴
Getting Ready to Deploy	2.62 (1.08)	---	---
Changes in Unit Leadership	1.92 (1.06)	1.87 (1.16)	1.91 (1.13)
Having to Move Family to US	1.94 (1.31)	1.81 (1.26)	2.20 (1.42)
Army Drawdown & Cuts	2.63 (1.31)	2.58 (1.47)	2.48 (1.51)
Not Knowing Where Unit Will be Based	---	3.13 (1.71)	2.31 (1.46)
Missing Spouse	---	3.18 (1.50)	3.06 (1.41)
Uncertainty About Where Family Will Live	1.63 (1.11)	2.55 (1.70)	2.05 (1.56)
Boredom	---	2.58 (1.43)	2.45 (1.22)
Lack of Ready Access to Transportation	---	2.43 (1.42)	2.47 (1.42)

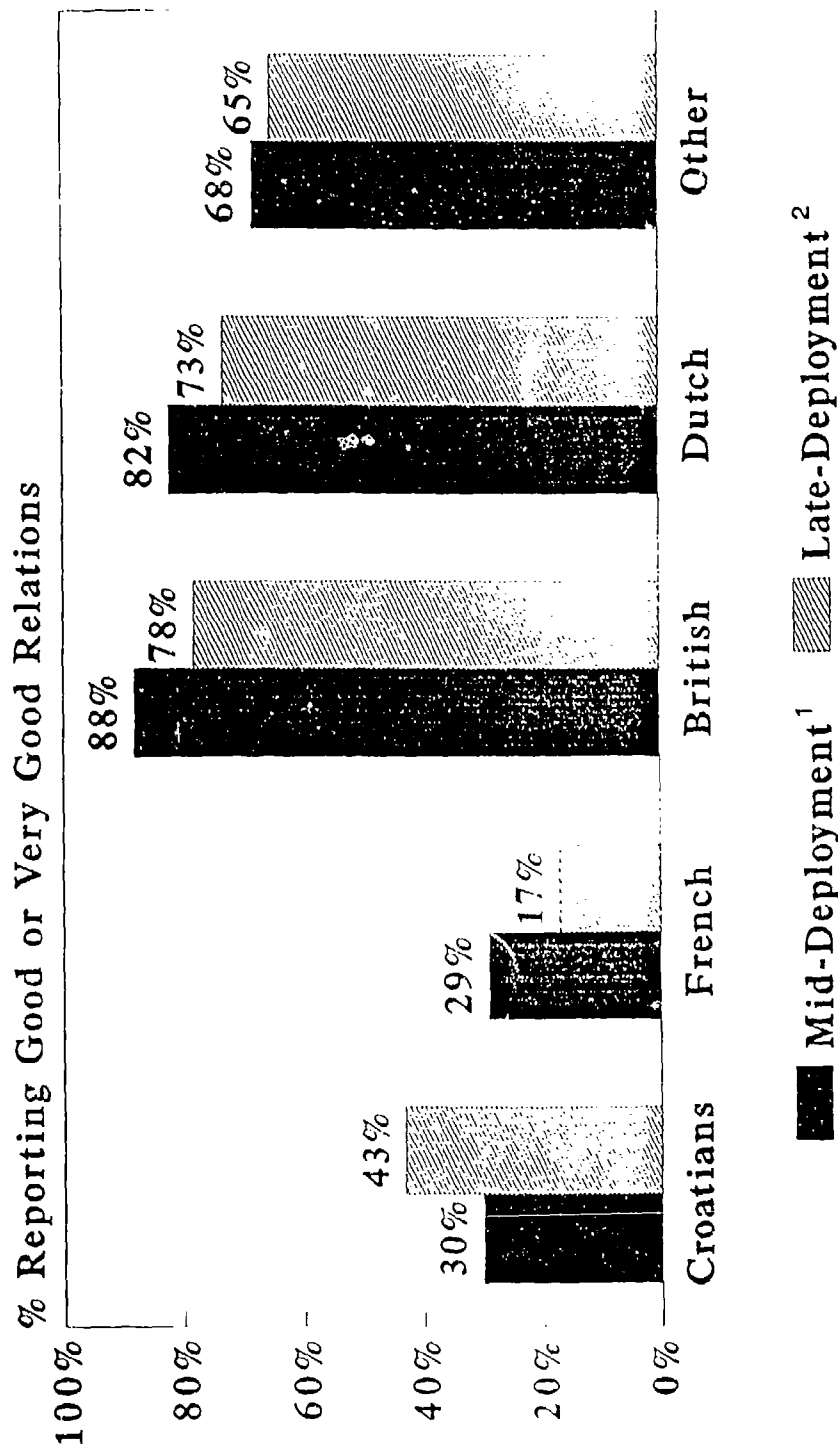
¹Rated on six-point Likert scale in terms of how much trouble or concern is caused by each stressor: 0=none, 1=very low, 2=low, 3=medium, 4=high, 5=very high. Some questions were not included in all versions of the questionnaires. These questions are marked by a line.

²N = 188.

³N = 128.

⁴N = 81.

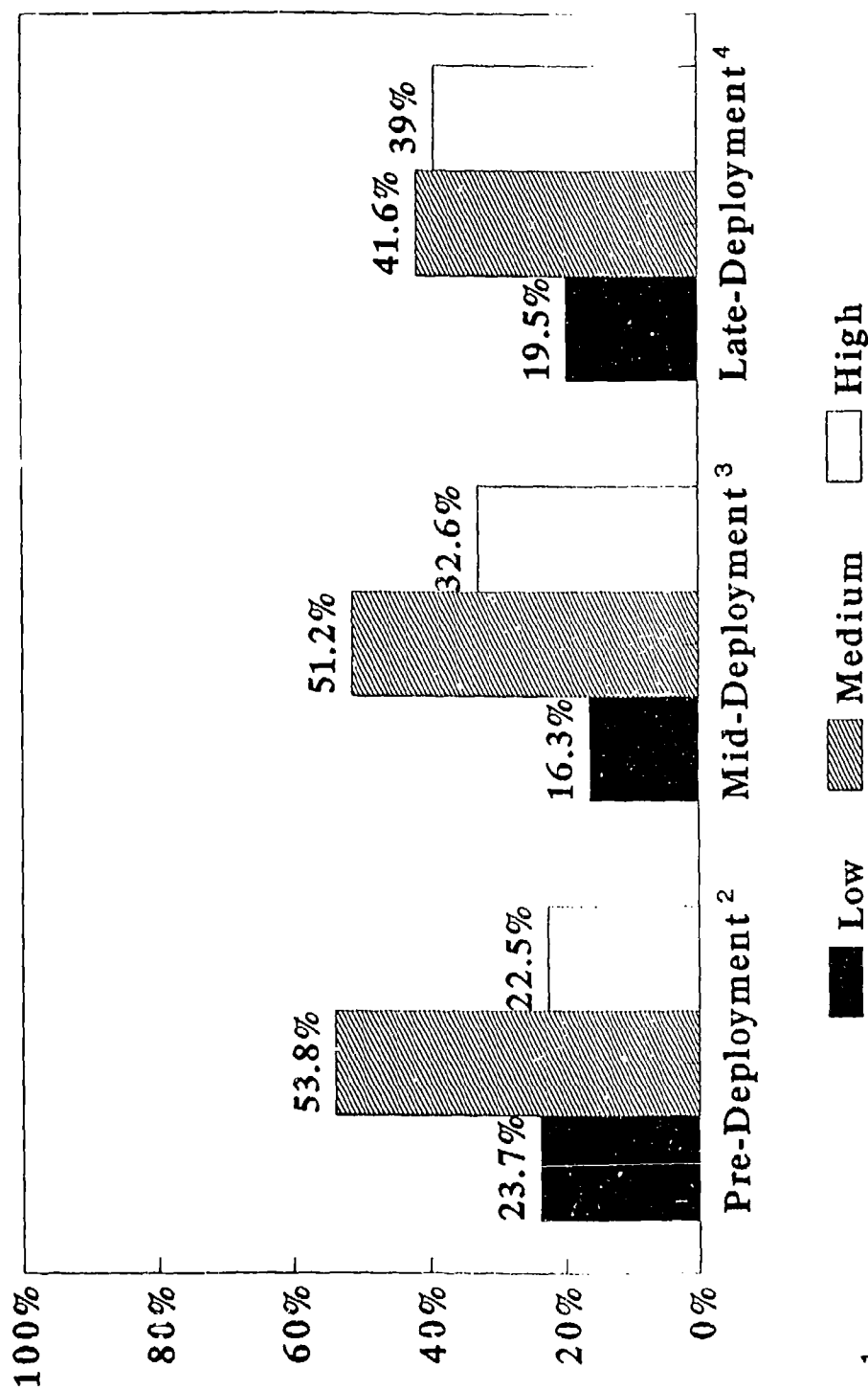
Figure 1
Good Relations with Other Nations
Reported Over Time



¹ N=128.

² N=81.

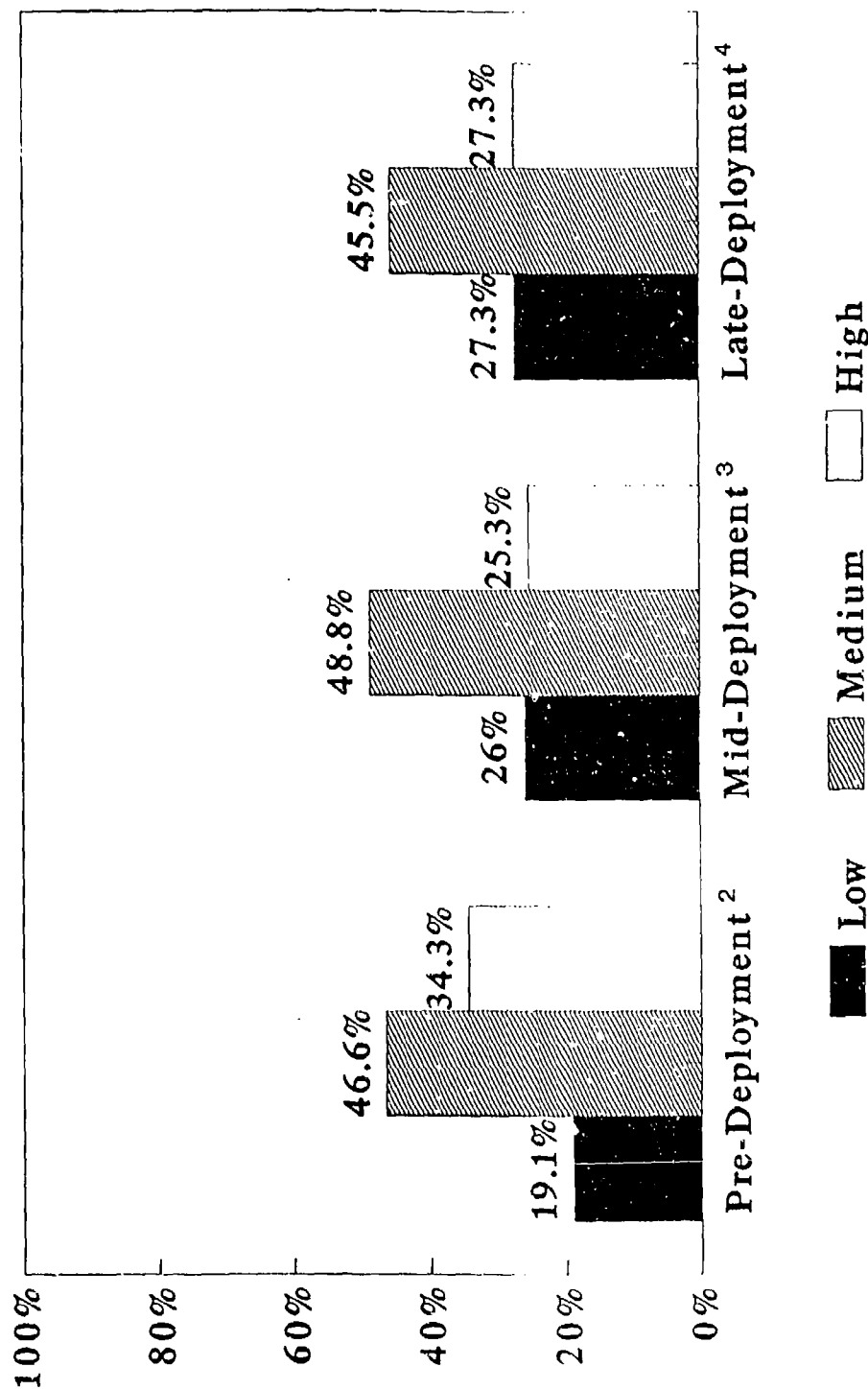
Figure 2
Unit Cohesion Reported Over Time¹



¹ "What is your level of cohesion in your unit at this time?"

² N=188. ³ N=128. ⁴ N=81.

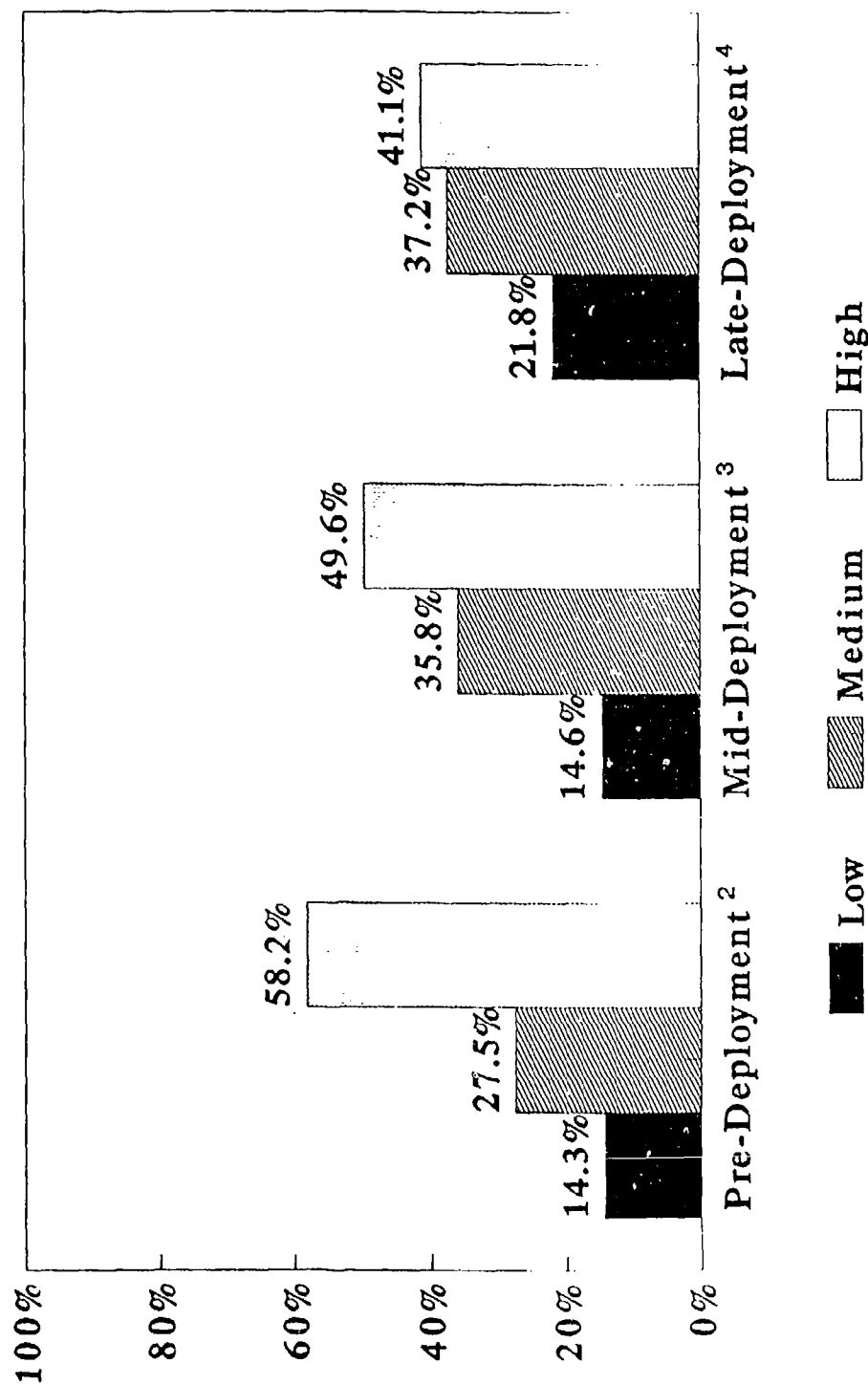
Figure 3
Unit Morale Reported Over Time¹



¹ "What is the morale level in the unit at present?"

² N=188. ³ N=128. ⁴ N=81.

Figure 4
Personal Morale Reported Over Time¹



¹"What is your personal morale level?"

² N=188. ³ N=128. ⁴ N=81.